MISSOURI COMMISSION ON PATIENT SAFETY
MEETING MINUTES
January 7, 2004
10:00 a.m. – 4:00 p.m.
Department of Health and Senior Services Bldg
Jefferson City, Missouri

OFFICIAL

Commissioners in attendance: Gregg Laiben, Thomas Cartmell, James Buchanan, Deborah Jantsch, Susan Kendig, Scott Lakin, Pamela Marshall, Alan Morris, Kathryn Nelson, Bea Roam, William Schoenhard, Stephen Smith, James Utley, Kenneth Vuylsteke, Lori Scheidt, and Tina Steinman.

I. CALL TO ORDER
Dr. Gregg Laiben, Chairperson
The meeting was called to order at 10:10 am. Silent roll call was taken.

Housekeeping items:

1. Lois Kollmeyer has been attending as the representative for DHSS in Dick Dunn's behalf. She is a resource and able to speak on DHSS matters to the Commission if needed. Since she contributes to Commission discussion at each meeting, she was invited to sit at the table with the other Commissioners so that her comments may be more readily solicited and heard.
2. Most Commissioners have sent Linda Bohrer comments or ideas about the progress of the Commission and the barriers to better patient safety that should be dealt with in Commission recommendations. Linda has consolidated all information sent to her into a handout for today. This document will be added to and edited as the commission work continues. Per Dr. Morris's request, the handout will be emailed to all Commissioners.
3. Commissioners should check the PSC web page frequently. Updates are added almost daily.
4. Linda emailed each Commissioner the JCAHO list of states with mandated reporting laws/requirements.
5. On Jan. 13 there will be a web cast hosted by the Commonwealth Fund regarding patient safety issues. Commissioners may wish to view this event.

6. Today's handouts include the consolidation of commissioners' ideas list as described above, a new contact list and an article presented to the Commission by Tina Steinman. The article is not available electronically.

Review of Draft Minutes from the previous meeting:

1. Written comments were received ahead of time from William Schoenhard regarding the joint presentation he did with Becky Miller on the Missouri Hospital Association.
2. MDI will correct grammar and punctuation errors.
3. There will be a revision to the minutes on page 15 of the draft minutes making the idea list a suggestion and not a motion by Scott Lakin.

The minutes were approved as amended by verbal vote with no objections.

Linda Bohrer asked audience members to sign the attendance log, and also to sign a list for public comment if they wished to address the commission today.

II. PRESENTATION ON PATIENT SAFETY FROM THE PATIENT ADVOCATE PERSPECTIVE

Ashley Allen, Executive Director of Missouri Watch

Ms. Allen thanked the Commission for an opportunity to speak on behalf of patients in Missouri who assume they will be safe and secure when they enter the health care system.

Ms. Allen's handouts included copies of overhead slides with summary information about the organization she represents. Detailed information regarding several victims of preventable medical errors was also included. Ms. Allen went into detailed discussion of one case. (handouts available)

In addition to information in the handouts, Ms. Allen made the following points:

- Missouri Watch educates health care professionals, consumers and policy makers through stories. Missouri Watch advocates for patient safety.
- The business take-over of the health care industry has meant poor care. No time is taken with patients. No consideration is given to patients and families and no dialogue occurs between patients and providers.
- Patients define "safe and secure" as clean, sanitary and comfortable. For example, employees of healthcare facilities are expected to wash their hands.
- Often, patients that Missouri Watch works with only want an acknowledgement that mistakes were made in their care, and an apology. Anger at the lack of accountability in the system is also a common issue. Most victims are not bitter, but they want honesty, respect and sensitivity from the providers involved.
- Missouri Watch believes bad doctors should be held accountable. There is a need for checks and balances.

- SRNA's (Student Registered Nurse Anesthetists) are a great concern due to the lack of controls while performing procedures as well as a lack of credentialing and training.

The handouts with detailed information regarding several victims may not be available electronically. The following points from the case Ms. Anderson discussed in detail should be noted:

- Numerous systemic errors lead to the serious injury of a young, healthy boy. In this case, the system problems began with teaching institutions long before either the patient or the practitioners involved ever entered a medical facility.
- In addition to systemic and human errors, medical records were deliberately altered in an attempt to cover up mistakes. Missouri Watch views this as malicious intent.

OPEN DISCUSSION:

Q: In the detailed case presented, it was noted that the family of the injured patient found out about the alteration of the medical record from a person in the institution that was acting as a whistleblower. Is this correct? Was there retaliation against this person? Does this kind of alteration happen often?
A: Yes, there was a whistleblower. In this case, that person has not suffered retaliation as far as MO Watch is aware, but retaliation against whistle blowers is common. Alteration of medical records is common. Whistleblower protection is important because of the frequency with which this kind of alteration occurs. Hiding errors and altering records is contrary to caring for people.
Q: There was a settlement in this case. Was there actually a lawsuit filed? Did the settlement include any agreement that the hospital would fix the problems highlighted in this case?
A: There was no lawsuit in this case. MO Watch doesn't know if there was any attempt to get the hospital to correct problems or work to assure similar problems weren't repeated.
Q: From MO Watch's point of view, what should the PSC do?
A: There should be more patient safety education for professionals and administrators. Hospitals should be required to have patient advocates, professional education programs and a culture of safety. System errors have got to be addressed, and training appropriate for the patients' needs should be assured at all times.
Q: The case points out numerous regulatory failures with regard to monitoring the educational process for SRNA's. Does MO Watch or Lori Scheidt know if the teaching institution involved was disciplined?
A: If the Board of Healing Arts had known about the case, it would have acted. Since the case occurred in the mid 90's, it's difficult to recollect on the spot if there was Board intervention. However, the Board of Nursing does not regulate graduate nursing institutions, which is where training of RNAs takes place. Discipline for doctors is also very light. If it occurs, doctors can simply go to another state. The doctor in this case,

who should have been overseeing the SRNA more closely, continues to practice at the same institution.
It was noted that two conflicting interests must be weighed at all times in such cases. On one side, the medical community needs legal protection to be able to openly discuss, investigate and learn from mistakes. On the other side, bad actors, such as practitioners who agree to alter medical records, must be held accountable. It may not be possible to completely satisfy both goals, but the attempt should be made.
Q: Was there any change in policies and procedures for the institution involved? Does MO Watch ever see commitments to change in settlement agreements? Are settlements used to shield providers from discipline? Could all settlements be required to include reporting to a state agency?
A: Settlements often include no admission of guilt. As to the last question, the answer is yes from MO Watch's point of view.

It was noted that settlements are a legal tactic to avoid the reporting that must occur when cases go to court. The PSC has discussed this problem in at least one earlier meeting. Policy makers and regulators can't do their jobs without the most complete possible information to work with. Settlements contribute to a lack of information reaching policymakers and regulators. These are issues that should be used as learning opportunities, but settlements prevent learning.
Dr. Smith, an anesthesiologist, commented that other factors are at work here, causing the system to fail. This case was characterized by a lack of critical information about the patient being evaluated, asked for, or present at all times when the boy was in the health care system. HIPAA privacy protections are causing some of these kinds of failures to get even worse. Also, while adverse events should get reported even if a settlement is reached, there must have been many near misses before this case actually occurred. Also, while whistleblower protection, and protection for the SRNA and physician involved, is important, the teaching institution should have been strongly disciplined.
Q: No one in this case seems to have been overseeing quality. As with airlines, why can't a checklist be used to assure that critical functions are carried out every time?
A: Hospitals do have checklists. The difference between the airline checklists and most medical checklists is that they look for different things. Airline checklists look for things that, if not checked off, will force a procedure to stop. Healthcare checklists tend to look for minimum affirmation that it's OK to proceed.
Susan Kendig agreed that, from the point of view of educating advance nurse practitioners, there are definitely checklists. The physician in this case was unclear as to the SRNA's level of training and preparation. Difficult discussion – need to understand how students have been educated and what the expectations are. Coordination of expectations needs to occur.
Q: Who regulates Certified Registered Nurse Anesthetist Programs?
A: Not the Board of Nursing. The Dept. of Elementary and Secondary Education accredits the schools. Particularly for out-of-state schools, the Missouri Board of Nursing has no authority for graduate programs – they accredit entry-level nursing programs that lead to initial licensure.

Some Commissioners expressed concern about proposed legislation to allow CRNAs to practice without physician supervision. Other states have already passed this kind of legislation. Some Commissioners stated strongly that physicians must be responsible and held accountable for the students they are entrusted to train and oversee.

III. UNIVERSITY OF MISSOURI NEAR MISS/ADVERSE EVENT REPORTING SYSTEM, "PATIENT SAFETY NET" OR "PSN"

Kathryn Nelson

Ms. Nelson provided handouts and a demonstration of the adverse event/near miss reporting system in use at the University of Missouri Hospital and Clinics. (handouts available) In addition to the points from her handouts, Ms. Nelson made the following points:

- UMC's system is 2 years old. It's also one of the oldest voluntary, health system electronic error reporting systems in the US.
- Staff accesses the PSN through computer terminals all over the hospitals and in the clinics as well., The PSN is Internet based, so staff can also enter records from home or anywhere they can get onto the Internet.
- Patients can also make a report via the Internet.
- Staff users can look at previously entered reports to see the resolution provided. Unit managers in the health system must document resolution for every entry. Patient users don't have the same type of access as staff, but are asked if they want feedback when they make entries.
- The PSN uses a harm scale with specific objective indicators, such as "Vital signs changed" or "Decreased level of consciousness" or "Transferred to a higher level of care".
- The system asks staff users for suggestions about how to fix the reported issues in each report. Staff suggestions are usually very good. They try to keep a non-blame focus.
- An assessment of culture was taken before the PSN was launched and again 2 years later. Staff is more aware of safety and are more likely to believe that errors are under-reported. The perception of blame has not improved.

Follow-up discussion:
Q: One of the questions that managers answer as part of their resolution allows the manager to note if litigation is expected. Why is this asked? Wouldn't this cause staff and managers to change how and what is entered in the system? Should a litigation flag go to lawyers? Is the information in the system discoverable?
A: As to the last question, the answer is yes and no. Safety reports within the PSN are not considered discoverable (like incident reports within health care institutions.). Comments are discoverable. This is what UMC lawyers have advised.
Tom Cartmell additionally commented that case law provides some guidance about what's discoverable and what isn't. There are some attorneys that really want the information in incident or safety reports, and will go after it. Other attorneys don't even

ask for it because they don't think the battle to get it is worth the effort. Tom Cartmell suggested that one of the data fields in the PSN for describing suggested resolutions is questionable, because it contains an opinion, not a fact. Ms. Nelson noted this is one of the most important fields in the system because of the insight it provides.
Q: With regard to physicians entering information, in non-teaching settings, physicians are not employees. The institution does not pay their malpractice premiums. There might be a greater issue of fear of discoverability outside teaching institutions.
A: That's probably true. The UMC system includes Columbia Regional Hospital, which is not a teaching institution. It is expected that physicians practicing there will enter fewer reports than their University Physician counterparts.
Q: What is done with the information in the system? What concrete achievements can be attributed to the PSN?
A: There are several issues here. Retaliation for reporting may be an issue. Also, the worst possible outcome would be the creation of a massive database with no action or relevance. The goal of the data must be for fixing systemic problems and acting on the trends that become apparent. But the science behind using reports to improve safety is in its infancy. We believe that over time actual improvements will occur because reports are resulting in root cause analyses and quality improvement efforts.

Q: Does UMC use clustering algorithms to identify trends in reports?
A: Not yet. The goal is to reach this level of text analysis, but currently UMC is relying on the judgment of managers and the Clinical Improvement Office to identify trends.
Tom Cartmell and Ken Vuylsteke further discussed the field in the PSN that asks the user for suggestions to fix reported problems. PSN users are asked for their opinion about a possible solution. Opinions like this are solicited for improving the system and processes of care. However, Tom Cartmell believes this could make the information entered in this field discoverable because it's not a factual report of an incident. This information therefore does not qualify under Missouri's peer review law. There is no attorney/client privilege because no attorney is involved in formulating the suggested solution. In addition, the managers that are responsible for resolving any reported problem are not always healthcare professionals. They may include the heads of clinical engineering, plant maintenance or dietary. However, these positions are just as likely to be the most appropriate manager to take responsibility for a problem as any clinical manager. It is important for commissioners to understand why the current law doesn't seem to support system-wide adoption of a patient safety culture. The healthcare system includes non-clinical components that are therefore not protected under the current law. **Missouri's peer review statute really should be changed.**
Q: Has UMC found that the PSN helps to integrate risk management and clinical improvement?
A: Developing the PSN was not necessarily an easy process. For example, the Departments of Pharmacy, Risk Management, Nursing, etc. had to agree to use the same system, but we were able to accomplish this. The clinical improvement and risk management offices are right next door, but risk management investigations are not entered in the PSN. The PSN is strictly for safety improvement and complaint management. Generally, the risk manager does not have responsibility for resolving safety issues, but can see all reports in the PSN.

Q: How do you know if a resolution is good? What if repeated issues occur?
A: The PSN is a decentralized system. It uses the unit managers for developing solutions with oversight by their line managers and the Clinical Improvement Office. The patient safety manager sees herself as a mentor for the unit managers, but is not responsible for policing resolutions. Managers need to be good system investigators, but this generally isn't taught in their professional schools. It's a new skill for many and can often be hard to teach.
Q: With regard to identifying trends, what about misidentification of problems?
A: It happens. The system allows unit managers to look at the resolutions of their peers. They can also ask to bring in other managers if they feel a solution lies outside their own unit and re-route reports to appropriate managers if necessary.

The Commission broke for lunch at noon and reconvened at 12:45.

IV. GEORGIA PARTNERSHIP FOR HEALTH AND ACCOUNTABILITY ("PHA") RECOMMENDATIONS/OUTCOMES/ONGOING EFFORTS

Vi Naylor, Executive Vice President, Georgia Hospital Association

Ms. Naylor's first comment was that improving patient safety is not easy and will not happen quickly. If the Commission desires a quick fix, they can stop now.

Ms. Naylor provided copies of the slides that accompanied her presentation. (handouts available) In addition to the points in her handouts, Ms. Naylor made the following points:

- There are both similarities and differences between Missouri, Georgia and any other states seeking to improve patient safety. However, certain tasks and procedures should be widely adopted. The presentation today should high light these areas.
- Collaboration with public and private entities and hospitals is essential.
- Given Georgia's experience, she did not feel the issue of voluntary vs. mandatory reporting was critical.
- Efforts to improve safety hinge on providers' willingness to share information.
- Georgia's PHA has been criticized as a system where the fox guards the hen house because the hospital association has played a leading role. However, Georgia hospitals that participate in the PHA have improved faster than the national average. This belies the criticism and shows how bringing hospitals and their trade associations in early helps develop an effective safety initiative. Initially, not all hospitals were required to participate, but they are now.
- The Georgia initiative viewed evidence-based medicine as a safety issue. The hospitals didn't really support this and continue to have litigation concerns.
- It's important to have a disclosure policy and also to have educational materials that raise physician comfort with patient disclosures. Physician pushback is reduced when physicians are partners with others in an effort that everyone agrees to.

- Georgia uses an award system to recognize high performing hospitals. Recognition resulted in more hospitals interested in working in the system and applying for the award. This was especially true for small critical access hospitals, because they had low estimates of their ability to contribute meaningful information to other hospitals.
- Georgia placed high importance on having all stakeholders involved in developing a statewide improvement system. This made the meetings very long, and made the task seem overwhelming at times. However, because the needs of all stakeholders were addressed, all stakeholders have worked hard to make the PHA succeed.
- Once all stakeholders are at the table, it's important to agree on a vision and guiding principals that will be useful in times where conflicting interests and protracted debates threaten progress.
- Communication of results and best practices has been one of the hardest things to accomplish, and continues to be a major challenge for Georgia.
- Protection from litigation is essential. Georgia's peer review law is more flexible than Missouri's. It includes protection for non-clinicians as long as primarily clinicians are involved. The major activity has to be health care improvement. The quality improvement initiative is careful to emulate what a hospital peer-review committee would do in order to stay inside the bounds of this protection. This is the website for Georgia's peer review law.
- Because there are so many stakeholders in the healthcare system, division of work is a universal essential.
- Georgia's PHA executive committee handled some divisive issues initially, but hasn't needed to meet in almost 2 years.
- Georgia's PHA decided not to publicly report rates. Improvement is the goal, not blame. Georgia publishes which hospitals participate in the PHA.
- The focus of safety initiatives should be on prevention, which necessitates reporting near misses.
- Reporting requirements can put additional burdens on hospitals. Take advantage of reporting that is already occurring.
- Medicaid and Georgia's state employee health plan, as two of the largest purchasers in the state, wrote a requirement in their contracts that participating hospitals must also be involved with a state-wide improvement initiative. Since there is only one to choose from, this was an extremely effective incentive for hospitals. If a hospital's performance doesn't improve, it will be dropped from the PHA. This will affect Medicaid and state employee health plan reimbursement.
- The PHA provides hospitals with feedback about how they compare to their peers, but only after a hospital has made 75 entries of its own.
- Georgia tried several styles and frequencies of communication. Settled on weekly email, unless there's an urgent issue.
- Physician champions are a necessity.

OPEN DISCUSSION:

Q: Are reportable events always sentinel events, or are less serious events also reported?
A: Georgia adopted a scale of events that must be reported. The PHA allows hospitals to meet public reporting requirements and also keep confidentiality. However, if a complaint becomes public through some other source, such as the media, then it's public. The PHA has authority to do site visits and can decide to make an issue public.
Q: Please clarify if PHA information is public?
A: The PHA sends quarterly reports to the state employee health plan and Medicaid on which hospitals are participating. Hospitals can publicize any quality awards they win.
Q: What would Georgia do differently?
A: Limit the amount of time spent on developing the program. Don't reinvent the wheel. Take advantage of work that's already being done.
Q: Why are non-hospital providers considered essential in an initiative that's primarily hospital driven?
A: Other providers were concerned that an undesirable mandate would be placed upon them if they didn't voluntarily participate. The PHA continues to need all stakeholders for credibility.
Q: How is information learned in the PHA transmitted out to providers not in the core group of stakeholders, such as skilled nursing facilities?
A: Hospital based SNFs have access to any information the PHA has. But the PHA is maxed out just with hospitals.
Q: Is the PHA fully funded?
A: No, only partially. The grant from the Academy for Healthcare Research and Quality runs out this year. PHA needs almost $1 million annually to operate. The hospital association made an initial investment, which lead to the AHRQ grant. Coca-Cola made a significant contribution. They contributed this money because the PHA showed results.

The Commission took a break at 1:50 and reconvened at 2:05.

V. PRESENTATION BY GRAPHIC SURGERY

Dr. Patricia Gelnar, President and Co-founder

Dr. Gelnar provided a folder of handouts and also gave a demonstration of their product, an Internet-based educational tool that provides information on a wide range of common surgical procedures. The tool also provides tracking of what the patient has been informed of, and what the outcomes are for each patient.

Dr. Gelnar thanked the Commission for the opportunity to present. In addition to the information in Dr. Gelnar's handouts, she made the following points:

- The biggest drivers of the malpractice crisis are also the most correctable.
- The amount of money spent on unnecessary surgery and complications is not well studied. The most recent information Graphic Surgery could find was dated from 1976.

- The PSC should talk to employers about spending on unnecessary surgery. There is high interest from the employer sector in addressing the malpractice crisis and reducing medical costs.
- One Missouri health plan reported that 30% of total costs are associated with surgeries.
- There are no silver bullets to help resolve the malpractice crisis. Multiple tools and approaches are necessary because the problem is multi-faceted.
- In spite of efforts to improve safety, the malpractice crisis shows that public trust in the healthcare system continues to deteriorate.
- Money spent on malpractice coverage and litigation is money that could have been spent on patient care. Perception that settled cases are frivolous isn't right because the cost of settlement is still high. Once a suit is filed, everyone loses.
- Tort reform isn't the answer. Non-economic damages don't account for the largest portion of awards.
- Under the current reimbursement systems, not only are providers not paid to spend time talking to patients, they're penalized for it. The Graphic Surgery product offers a computer-based program that provides patients with about 25 minutes worth of information, during which a medical provider doesn't have to be present. This takes some of the burden off providers, but also improves the patient's confidence with receiving information at their own pace. The system also allows the patient to go back if they don't think they understood everything. Finally, the system allows temporary Internet access for patients who want to revisit information from home or work. About 70% of patients take advantage of the opportunity to revisit the information later.
- Too many discretionary surgeries are performed because patients are unwilling to make lifestyle changes. This unwillingness stems from a perception that there is a surgical fix that is "effortless". Proper education on the procedures, risks and expected outcomes will reduce the volume of surgery performed.
- There needs to be an objective way to address bad actors.
- "Shoppers" are not the same as "consumers". Shoppers evaluate and compare their options. Consumers just consume. Studies show that consumers want information on the quality and expertise of doctors. The Graphic Surgery product offers a way to automatically capture and analyze outcomes information for every procedure performed. This will lead to the development of comparative information that consumers need to be "shoppers".
- Informing patients of possible bad outcomes includes telling patients what they can do to aid their own recovery, and the consequences of failing to follow medical advice.
- Graphic Surgery adhered to basic educational principals in developing their product. Information is presented in small segments. Text at an 8th grade reading level is accompanied by audio and pictures, to address different learning styles. The pictures used are essentially cartoons, with no blood, and with enhanced color schemes to clearly show the basic anatomy involved.
- Information about what the patient was informed of, and whether or not the patient revisited the information later away from the doctor's office, is tracked and stored for 10 years, or forever in the case of obstetrical patients.

- The PSC should find the low-hanging fruit in terms of the easiest issues to tackle and those that will have the most impact. Surgery is it.
- Malpractice underwriting is too generic. Outcomes tracking will lead to more scientific underwriting.
- PSC should look at implementations in multiple industries, and tracking proper use of procedures, and outcomes.
- With regard to reducing the risks of surgery, lots of types of technology are being developed, but different systems don't talk to each other. This is becoming a big problem. There is a group in Chicago that can help the PSC with this.

  The National Alliance for Health Information Technology
  One North Franklin Street
  30th Floor
  Chicago, IL 60606
  www.nahit.org

OPEN DISCUSSION:

Q: The handouts mention Texas's requirement for adequate patient education. What is the definition for inadequate education?
A: They're working on it through a board. A list of common procedures and possible complications for each is being developed. Courts will enter whether or not a doctor provided education on each complication.

Q: How many patients decide not to go through with surgery after viewing the Graphic Surgery information?
A: That's not tracked, although some doctors have said they use the product to talk people out of having a surgery, and to encourage people to work harder at more conservative therapies and life-style changes.
Q: Is it patient demand or the financial rewards that drive over utilization of surgery?
A: Both.
Q: Wasn't this product specifically referenced in a senate resolution last year? What happened with that?
A: Senate Resolution 11 was for a pilot patient education project. No money was set aside for it. Graphic Surgery is searching for partners and funding to carry out the study.
Q: Does the product talk about what life will be like after the surgery, even with no complications?
A: Yes. Statistics on the likelihood of continued symptoms are provided. The definition of "unnecessary" is a moving target. Some procedures are more clearly necessary than others. Overly utilized procedures tend to be for pain and where necessity is hard to define.
Q: Has the product been assessed for how well patients learn and how much information they retain?
A: Yes. Graphic Surgery conducted focus groups that did pre- and post- assessments of patient understanding for short-term retention. Long-term retention has not been tested.

VI. DISCUSSION OF PATIENT SAFETY ISSUES ASSIGNMENT AND TODAY'S PRESENTATIONS

At the last meeting, Commissioners were asked to write problem statements. Commissioners can still send ideas to Linda. Several general areas were identified, per the handout. The PSC should try to address two questions:

1. Is this list of categories complete?
2. How will the work of the PSC actually happen? Will Commissioners work in smaller groups? On their own? As one large body?

Q: Were these categories vetted against the list of topics from the first meeting?
A: No. That still needs to be done.

Open discussion centered on the need for consistency in data collection, but it was agreed that no data set would ever be perfect. In part, this is due to the constantly changing nature of medical practice. **If data on medical errors is collected, the sources must be protected from litigation. If data is collected, it must be used.** "Use" means to solve problems with it. **Some Commissioners expressed a desire to have a permanent state-wide body of some kind continue after this Commission is over.**

Scott Lakin suggested that there is power to effectuate change in simply writing statements/goals/ guiding principals. The PSC could state a vision for what should be in Missouri and leave it to public and private entities to pursue those pieces to which each entity is best suited. MDI's medical malpractice report is a good example of this. MDI made 12 recommendations, half of which have been acted on without the need for legislation. But, others would clearly require legislation. Term limits for legislators make it hard for lawmakers to be responsible for a 10-year health policy plan. But future legislators could rely on the statements adopted and acted upon by other entities. Commissioners liked this idea. **Some Commissioners wanted highly specific statements in order to avoid unintended consequences. However, Mr. Lakin advised that specifics lead to resistance.**

The Commission agreed that the first step is to flesh out the list of problem statements. Commissioners should continue to send Linda their ideas. At this time, there will be no "editing" of ideas.

The meeting was adjourned at 4:10.